Russell's Dental Lab, LLC
dba New Horizons Dental Lab

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DR. _____ DATE _____

CITY _____ STATE _____

PATIENT'S NAME _____ IS YOUR SHADE GUIDE ENCLOSED? YES ☐ NO ☐

SEX: MALE ☐ FEMALE ☐ AGE _____ HARD SPLINT _____ SOFT SPLINT _____

PERSONALITY: VIGOROUS ☐ MEDIUM ☐ SOFT ☐

FOR LABORATORY USE ONLY

DATE RECEIVED	PATIENT'S NEXT APPT.	OUR DEL. TIME & DATE

SHADE SELECTED: BIOBLEND _____ BIOFORM _____

PLEASE PROVIDE COMPLETE INSTRUCTIONS

Full payment is due upon delivery. Orders not paid within thirty (30) days of delivery are subject to a delinquency charge of 12% per annum.

DR. SIGNATURE _____ **LICENSE NO.** _____

Patient Right

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Patient Left

If some other method is used please indicate on prescription.